UnityPoint Health

Trinity Pioneer

ACCOUNTABLE CARE ORGANIZATION

Pam Halvorson – Regional Vice President, Clinic Operations, UnityPoint Clinics , Executive Sponsor ACO

Study Committee Charge

- Review and make recommendations for the formation and operation of integrated care models in Iowa;
- Review integrated care models adopted in other states that integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams;
- Recommend the best means of incorporating into integrated care models nonprofit and public providers that care for vulnerable populations;
- Review and make recommendations regarding development and implementation of a statewide medical home infrastructure to act as the foundation for integrated care models;
- Review opportunities under the federal Affordable Care Act for development of integrated care models;
- Address consumer protection, governance, performance standards, data reporting, health information exchange, patient attribution, and regulation issues relative to integrated care models; and perform other duties specified in the legislation.

UnityPoint Health – Fort Dodge

Trinity Regional Medical Center
Iowa Health System

→

UnityPoint Health
Trinity Regional Medical Center

Trimark™
Physicians Group

→

UnityPoint Clinic

Berryhill Center
for Mental Health

→

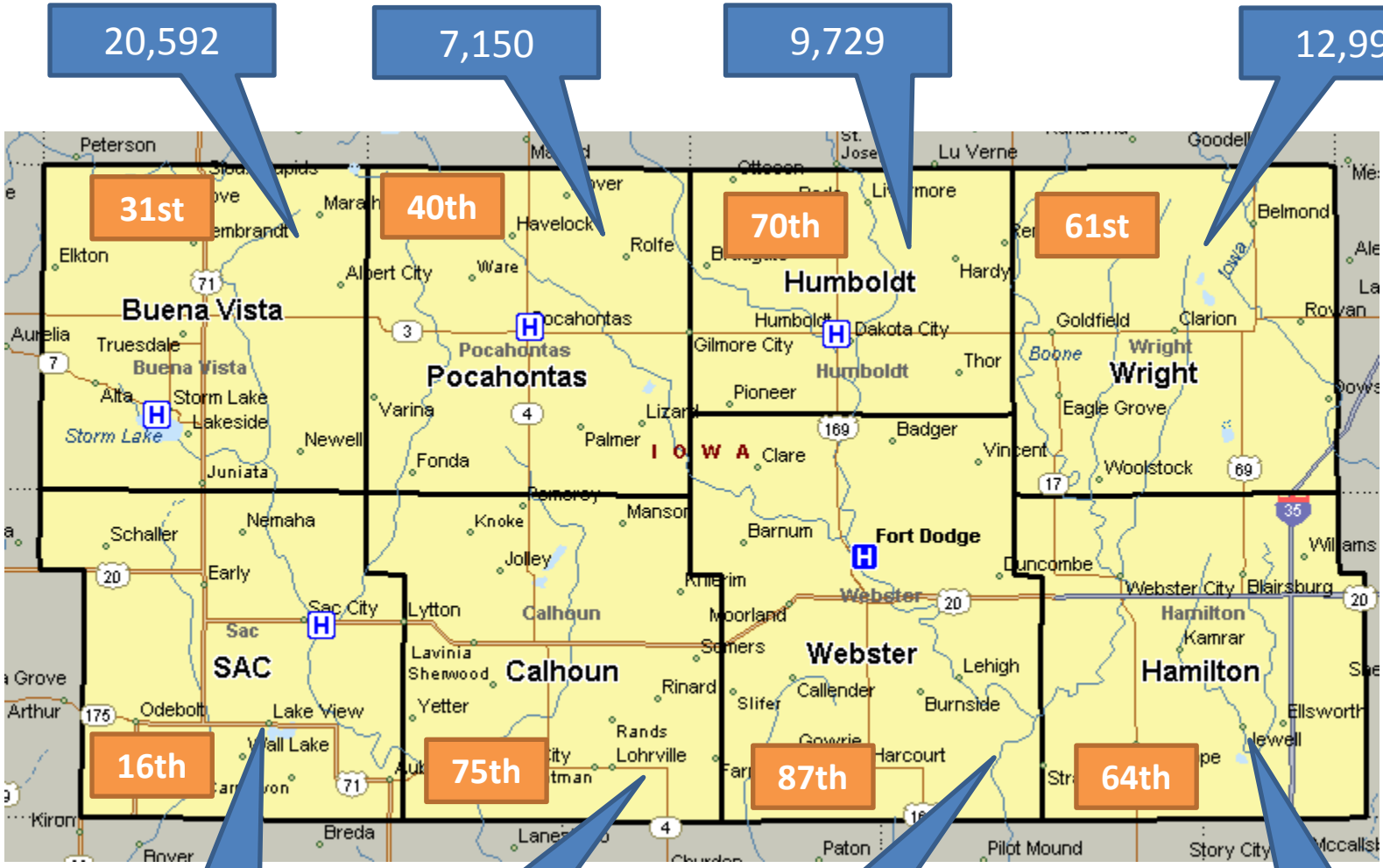
UnityPoint Health
Berryhill Center

Iowa Health
Home Care
Iowa Health System

→

UnityPoint at Home

UnityPoint Health



UnityPoint Health

Model for Trinity Pioneer ACO – Achieving our Aim

AIM: Leverage every aspect of our "community" to achieve Best Outcome for Every Patient Every Time

Primary Care Community

Primary Drivers

Secondary Drivers

Promote and Maintain Health	Prevent Illness and Disability	Provide a Coordinated Care Experience	Manage Population Health	Support Choice Through the Lifespan
• Health-Risk Assessment • Iowa's Healthiest State initiative • Preventive screening • Health Education and Literacy • Wellness Program	• Patient access to PCP • Patient Centered Medical Homes • Common screening and assessment tools • Single, patient-centric care plan • Med Therapy Management • Mental Health Action Team	• Care transitions – Extended Care Facilities • Common Chronic Disease Management (ICCDM) – all care settings • Advanced Medical Team Navigators • Telehealth • Strategic Healthcare Partners • Critical Access	• Risk stratification • Med Therapy Management • Disease Management Coaching • Strategic Community Partners	Palliative Care: • Inpatient • Home-based • Clinic • Integration with PCP Hospice: • Hospice Home • Home-based

Home/Neighborhood - Schools - Business - Healthcare Agencies - Government -Recreation - Church/Spiritual

Developing Strategic Partnerships

Readiness to Change

Capacity to Risk

Skill in Collaboration Teams

Commitment Over Time

Enthusiasm to Innovate

Ability to Learn and Deploy

Strong Strategic Partner

Public Health / LTC / Critical Access Hospitals

Integration – Speaking a Common Language

Steering Committee
Promote/Maintain Health

Prevent Illness/Disability

Coordinate Care Experience

Manage Population Health

Support Choice through lifespan

TRINITY PIONEER
ICCDM, HRA

MY CARE PROFILE

UNITY POINT AT HOME
MTM
ER DISCHARGE

LONG TERM CARE
READMISSION WORK
TELEPHONIC DISEASE MGMT

AMT
PALLIATIVE CARE

Webster Co Health Dept.
Better Choices Better Health

Standardized PH assessments

Health Promotion/Health Maintenance/PH visits

Linking to "Other" PH programs: WIC, Maternal Child Health, Tobacco, Environmental Health, Community Transformation, BASICS, Senior Health

2011 Integration Year 1-Listened/Learned

- Pioneer planning meetings held weekly with participants and potential partners
- Public Health educated physicians and providers about the breadth and capacity of services available
- Community transformation grant was awarded to Webster County
- **Ah-Ha Moment**
- Public Health was initiating and coordinating several counties through the Maternal/Child Health program
- Trinity approached Public Health to provide input into Pioneer application
- Pioneer awarded to UnityPoint
- Webster County Health Department formally invited to sit steering and work groups in the Pioneer

Integration Year 2
Integration/Communication

- WCHD serves on several ACO committees to provide “population” input
- Pediatric Providers integrated a care coordination system with the Maternal/Child Health Title V Program
- Continuum of care for the client - guidance of public health
- ICCDM and Better Choices Better Health
- My Care Profile – standardized public health assessments
- Unity Point at Home – Public health home visitation programs
- **Commonwealth Institute Assessment – New Perspective**
- Regional approach to integrate services - Public Health Summit
- Continued communication of public health programs integrated into care of the population – Smoking Cessation Programs
- Pioneer ACO mission/vision - Discussed with Local Board of Health

Integration Year 3
Communication and Integration of a structure/system

- Continued committee meetings and sub-committee meetings
- Integrated Health Home "model"
- Asthma Project with primary care providers, school system, public health
- ER Discharge/Readmissions - connecting to public health programs
- Discovered a barrier for some clients to receive immunizations - Coordinated Adult Immunizations/ Hep A & B through public health
- Tobacco screenings - Tobacco Cessation Intervention
- Non-threatening regional approach to integrate strategies outside of Webster County
- ICCDM within Pioneer ACO - Public health trained neighboring counties in the Better Choices Better Health curriculum
- Interfacing software to communicate between public health (possibly regionally) and primary care providers .
- Tri-Navigation Initiative – PCP Navigator, Mental Health Navigator and public health navigator

Lessons Learned – Strategic Alignment

- It is NOT business as usual
- It is NOT a program
- Evolutionary process - continuous
- Ask questions
- Keep everyone informed of the vision/mission
- Continually analyze: structure, capacity, workforce, partners
- Take advantage of opportunities
- Communicate, communicate, communicate
- What is best for the patient/client is your goal
- Silo's are not allowed

"Take Away" Statements

- It is a structure with mutual accountability to the patient/client
- Relationships needed for integration take time
- Prescriptive and Rigid rule making kills innovation
- Resources at hand determine speed of innovation
- Everyone will not have insurance ~ there will still be barriers to health care coverage and barriers to access
- Pioneer provides a learning model